DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 00-004

2. STATE: Indiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: April 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 10.2million-35.9million
b. FFY 2001 $ 10.2million-35.9million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19A, page 1G and pages 3-16
Attachment 4.19 B, page 2.1 J.H.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19A, page 1G and pages 3-16

10. SUBJECT OF AMENDMENT:

Disproportionate Share Hospital payments

* fiscal impact is based solely on changes to Page 1G, there is no fiscal impact to HCFA for the changes in the remainder of pages as the changes redistribute existing funds among the hospitals

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Kathleen D. Gifford

13. TYPED NAME:
Kathleen D. Gifford

14. TITLE:
Assistant Secretary, OMPP

15. DATE SUBMITTED:
6/29/00

16. RETURN TO:

Kathleen D. Gifford, Asst. Secretary
Office of Medicaid Policy and Planning
402 West Washington Street, Room W382
Indianapolis, IN 46204
Attention: Tracy Brunner, State Plan Coordina

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
6/30/00

18. DATE APPROVED:
12/20/00

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
4-1-00

20. SIGNATURE OF REGIONAL OFFICIAL:
Cheryl A Harris

21. TYPED NAME:
Cheryl A. Harris

22. TITLE:
Associate Regional Administrator
Division of Medicaid and Insurance Oversight

23. REMARKS:

RECEIVED
JUN 30 2000
DMIO - IL/IN/OH

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JUN 30 2000
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FORM HCFA-179 (07-92)

Instructions on Back

State of Indiana

Attachment 4.19A
Page 1G

"Rebasing" means the process of adjusting the base amount relying upon the most recent reliable claims data, cost report, data, and other information relevant to hospital reimbursement.

"Relative weight" means a numeric value which reflects the relative resource consumption for the DRG to which it is assigned. Each relative weight is multiplied by the base amount to determine the DRG rate.

"Routine and ancillary costs" means costs that are incurred in providing services exclusive of medical education and capital costs.

"Transfer" means a situation in which a patient is admitted to one (1) hospital and is then released to another hospital during the same episode of care. Movement of a patient from one (1) unit within the same hospital will not constitute a transfer unless one (1) of the units is paid under the level-of-care reimbursement system.

"Transferee hospital" means the hospital that accepts a transfer from another hospital.

"Transferring hospital" means the hospital that initially admits then discharges the patient to another hospital.

MEDICAID INPATIENT PAYMENTS FOR SAFETY-NET HOSPITALS

"Safety-net hospital," for purposes of this section, means an acute care hospital, licensed under IC 16-21, the Indiana hospital licensure statute, and qualified under Section II.E. of this plan as a disproportionate share hospital.

(A) For the state fiscal years ending on or after June 30, 2000*, safety-net hospitals with more than 150 interns and residents, located in a city with a population of over 600,000, and safety-net hospitals which are the sole disproportionate hospital in a city located in a county having a population of more than four hundred thousand (400,000) but less than seven hundred thousand (700,000), which hospitals are also historical disproportionate share hospitals, shall receive reimbursement, subject to the terms of subsection (B) of this section, in an amount calculated by the office from the hospital's cost report filed with the office for the hospital's fiscal period ending during the state fiscal year, equal to the difference between:

(1) the amount of Medicaid payments to the hospital, excluding payments under Section III of this Plan, for Medicaid inpatient services provided by the hospital during the hospital's fiscal year, and
(2) an amount equal to the lesser of the following:

(A) The hospital's customary charges for the services described in subdivision (1).

(B) A reasonable estimate by the office of the amount that would be paid for the services described in subdivision (1) under Medicare payment principles.

The office may also make payments to all other safety-net hospitals in the manner provided in subsection (A) of this section, subject to the provisions of subsection (B) of this section.

(B) Payments described in subsection (A) of this section are subject to the availability of funds representing expenditures eligible for federal financial participation pursuant to 42 U.S.C. 1396b(w)(6)(A) and 42 CFR § 433.51.

*This new payment methodology will apply for Medicaid services on or after April 1, 2000, but will be calculated as set forth in this section. For the state fiscal year ending on June 30, 2000, the state may reimburse, under this section, each safety-net hospital eligible for such reimbursement in an amount not to exceed one-fourth of the amount calculated under the formula described in this section. For state fiscal years ending after June 30, 2000, the state may reimburse, under this section, each safety-net hospital eligible for such reimbursement in an amount up to one hundred percent (100%) of the amount calculated under the formula described in this section.

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(2) A corporation incorporated under the provisions of IC 1971, 23-7-1.1, the "Indiana General Not for Profit Corporation Act";

(3) A nonprofit corporation incorporated in another state; and

(4) A university of college.

(E) "Disproportionate Share Hospital" has the following meaning: An Acute Care Hospital licensed under IC 16-21, the Indiana hospital licensure statute; a State Mental Health Institution under the administrative control and responsibility of the Director of the State Division of Mental Health; or a Private Psychiatric Institution licensed under IC 12-25, that qualifies as an inpatient hospital eligible for DSH payments as set out in the requirements in section 1923 of the Act,

(1) whose Medicaid Inpatient Utilization Rate is at least one standard deviation above the Statewide Mean Medicaid Inpatient Utilization Rate for such provider hospitals receiving Medicaid payments in Indiana, or,

(2) whose low income utilization rate exceeds twenty-five percent (25%).

No hospital may be a disproportionate share hospital unless the hospital:

(i) has a Medicaid utilization rate of at least one percent (1%); and
(ii) has at least two (2) obstetricians with staff privileges, who have agreed to provide obstetric services to individuals entitled to such services under the Indiana Medicaid state plan. For a hospital located in a rural area (as defined in Section 1886 of the Social Security Act), the term obstetrician includes a physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This provision, (ii), does not apply to a hospital the inpatients of which are predominately individuals under 18 years of age; or which did not offer non-emergency obstetric services as of December 21, 1987.

For state fiscal years ending after June 30, 1997, eafch hospital's eligibility for disproportionate share payments under this section shall be based on utilization and revenue data from the most recent year for which an audited cost report for the individual hospital is on file with the office.

(F) "Historical disproportionate share provider" has the following meaning:

An acute care hospital licensed under IC 16-21 which was eligible for a disproportionate share hospital payment for the state fiscal year ending on June 30, 1998, and which is eligible for a disproportionate share hospital payment in the year for which payments are being calculated.

(G) "Municipal Disproportionate Share Provider" has the following meaning: An acute care hospital licensed by the State of Indiana and established and operated under Indiana Code 16-22-2 or 16-23, that based on utilization and revenue date from the most recent year for which an audited cost report is on file with the office, has a Medicaid Inpatient Utilization Rate greater than one percent (1%). IC 16-22-2 and 16-23 are enabling statutes for county and city-county hospitals under Indiana law.

(H) "Community Mental Health Center Disproportionate Share Provider" has the following meaning: A community health center designated as such by the state division of mental health, that receives funding under Indiana Code 12-29-1-7(b) or from other county sources, that provides inpatient services to Medicaid patients, and whose Medicaid Inpatient Utilization Rate, based on utilization and revenue data from the most recent year for which an audited cost report is on file with the office, is greater than one percent (1%). Indiana Code 12-29-1-7(b) provides for property tax funding by individual counties of community mental health centers situated in those counties.

(I) "Medicaid Inpatient Utilization Rate" for a provider, has the following meaning: A fraction (expressed as a percentage) for which:

(1) the numerator is the provider's total Medicaid inpatient days in the most recent year for which an audited cost report is on file with the office; and

(2) the denominator is the total number of the provider's inpatient days in that same cost reporting period, where inpatient days includes each day in which an individual (including newborns, Medicaid managed care beneficiaries, and Medicaid beneficiaries from other states) is an inpatient in the hospital, whether or not the individual is in a specialized ward (including acute care excluded unit distinct part subproviders of the provider) and whether or not the individual remains in the hospital for lack of suitable placement elsewhere. The term "inpatient days" includes days attributable to Medicaid managed care recipients and Medicaid eligible patients. The term does not include days attributable to Medicaid patients between the ages of 21 and 65 in Institutions for Mental Disease.

(J) "Statewide Mean Medicaid Inpatient Utilization Rate" has the following meaning: A fraction (expressed as a percentage) for which:

(1) the numerator is the total of all Medicaid enrolled hospital providers' Medicaid Inpatient Utilization Rates in the most recent year for which audited cost reports are on file with the office; and

(2) the denominator is the total number of all such Medicaid enrolled provider hospitals.

In calculating the Statewide Mean Medicaid Inpatient Utilization Rate, the Medicaid agency shall not include in the statistical database for the statewide mean calculation, the Medicaid Inpatient Utilization Rates of providers whose low income utilization rates exceed twenty-five percent (25%).

(K) A provider's "Low Income Utilization Rate" is the sum of:

(1) a fraction (expressed as a percentage) for which:

(A) the numerator is the sum of the following:

(i) the total Medicaid patient revenues paid to the provider during the most recent year for which an audited cost report is on file with the office; plus

(ii) the amount of the cash subsidies received directly from state and local governments, during the most recent year for which an audited cost report is on file with the office, including payments made under the hospital care for the indigent program; and

(B) the denominator is the total amount of the provider's revenues for patient services (including cash subsidies) during the most recent year for which an audited cost report is on file with the office; and

(2) a fraction (expressed as a percentage) for which:

(A) the numerator is the total amount of the provider's charges for inpatient services during the most recent year for which an audited cost report is on file with the office that are attributable to care provided to individuals who have no source of payment or third party or personal resources, less the amount of any cash subsidies described in clause (K)(1)(A)(ii) above; and

(B) the denominator is the total amount of charges for inpatient services in the same cost reporting period.

The numerator in clause (2)(A) shall not include contractual allowances and discounts other than for indigent patients not eligible for medical assistance under an approved Medicaid state plan.

(L) For purposes of eligibility, utilization rate and payment adjustment determinations for State fiscal years ending after June 30, 1997, "utilization and revenue data from the most recent year for which an audited cost report is on file" means utilization and revenue data from the most recent cost report which is on file for each individual provider as of June 30 of the state fiscal year immediately preceding the fiscal year for which the determination of eligibility or the calculation or rates or the calculation of payment adjustments is being made, and which has been audited prior to the date on which the determination or calculation is made.

(M) For purposes of calculating DSH eligibility, audited is defined as a targeted limited scope desk review where the data used for DSH calculation is thoroughly reviewed and adjusted where necessary.

III. PAYMENT ADJUSTMENTS

A. Inpatient Disproportionate Share Payment Adjustment

Disproportionate Share Hospitals shall receive, in addition to their allowable regular claims payments and any other payment adjustments to which they are entitled, a disproportionate share payment adjustment calculated in the following manner:

(1) For each of the state fiscal years ending after June 30, 1995, a pool not exceeding two million dollars ($2,000,000) shall be distributed to all qualified private psychiatric DSH's licensed by the director the state department of health to provide private institutional psychiatric care, whose Medicaid inpatient utilization rates are at least one (1) standard deviation above the statewide mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana and/or whose low income utilization rate exceeds twenty-five (25%). The funds in this pool must be distributed to the qualifying hospitals in the proportion that each qualifying hospital's Medicaid inpatient utilization rate bears to the total of the Medicaid inpatient utilization rates of all hospitals in the pool as determined based on data from the most recent year for which an audited cost report is on file with the office for each potentially eligible hospital. In no instance will any hospital in this pool be entitled to disproportionate share amounts that when added to the hospital's other Medicaid payments yield a combined total reimbursement that exceeds 100% of the hospital's allowable cost of delivering Medicaid and uninsured care. DSH payments that are retrospectively determined to exceed this cap of 100% of allowable cost shall be recovered with interest by the OMPP.

(2) For each state fiscal year ending on or after June 30, 1995, a pool not exceeding one hundred ninety-one million dollars ($191,000,000) shall be distributed to all state mental health DSH's whose inpatient utilization rates are at least one (1) standard deviation above the statewide mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana or whose low income utilization rate exceeds twenty-five (25%). The funds in this pool must be distributed to the qualifying hospitals in the proportion that each hospital's low income utilization rate, multiplied by total Medicaid days, bears to the product of the same factors of all hospitals in the pool using data from the most recent year for which an audited cost report is on file with the office for each potentially eligible hospital.

Disproportionate share payments described in this section shall be made on an interim basis throughout the year as determined by OMPP.

B. DSH Payments to Acute Care Hospitals Licensed Under IC 16-21

1. For the state fiscal year ending after June 30, 2000, the following payment methodology will be utilized for the distribution of payments to acute care hospitals licensed under IC 16-21:

(1) The office will distribute disproportionate share payments to all qualifying acute care hospitals, in an aggregate sum which does not exceed the limits imposed by federal law and regulation, subject to the availability of sufficient state matching funds.

(2) Each qualifying hospital's "hospital specific limit" is the sum of all costs for services provided to uninsured patients, less any cash payments made by them, and all costs for services provided to Medicaid patients, less the amount paid to the hospital under the non-DSH payment provisions of the State Plan.

(3) The hospital-specific limit for each hospital shall be determined by the office taking into account data provided by each hospital that is considered reliable by the office based on a system of periodic audits, and the use of trending factors applied to such data. The office may require independent certification of data provided by a hospital to determine the hospital's hospital-specific limit.

(4) Hospitals defined in Section II(F) of this Plan as "historical disproportionate share providers" will receive 100% of their hospital-specific limit, subject to the limits imposed by federal law and regulation, sufficient state matching funds, and the payment provisions set forth in Section III.G. of this plan.

2. For the state fiscal year ending on June 30, 2000, qualifying Hospitals not defined as historical disproportionate share providers under Section II(F) of this plan will receive 33 1/3% of their individual hospital-specific limit. After the state fiscal year ending on June 30, 2000, each time the office redetermines eligibility of disproportionate share hospitals, the office will adjust disproportionate share providers by increments of 33 1/3 percent of each qualifying hospital's hospital specific limit, not to exceed 100% of the hospital specific limit. A hospital not defined as an historical disproportionate share hospital which is determined to be eligible for disproportionate share payments, following a prior period of ineligibility for such payments, will receive reimbursement in an amount equal to 33 1/3 percent of its hospital specific limit.

The OMPP may, however, adjust the disproportionate share payment specified above as provided for in 42 CFR 447.297(d)(3), allowing the state to make additional disproportionate share expenditures after the end of each federal fiscal year that relate back to a prior federal fiscal year. Each eligible hospital may receive an additional disproportionate share payment adjustment, if:

(1) additional funds are made available which are eligible for federal financial participation pursuant to 42 U.S.C. 1396b(w)(6)(A) and 42 CFR §433.51; and

(2) the total disproportionate share payments to each individual hospital, and all qualifying hospitals in the aggregate, do not exceed the limits provided by federal law and regulation.

The office may also, before the end of a state fiscal year, make a partial payment to one or more qualifying hospitals, if:

(1) sufficient funds are made available which are eligible for federal financial participation pursuant to 42 U.S.C. 1396b(w)(6)(A) and 42 CFR §433.51;

(2) the partial disproportionate share payment to each hospital does not exceed the limits provided by federal law and regulation; and

(3) no hospital qualifying for a disproportionate share payment for the same state fiscal year for which a partial payment is made will receive a net disproportionate share payment for that state fiscal year in an amount less than the amount the hospital would have received if no partial payment had been made before the end of the fiscal year.

C. Contributions by State of Indiana to the Medicaid Indigent Care Trust Fund

The office shall, in each state fiscal year, provide, for acute care hospitals licensed under IC 16-21 that qualify for disproportionate share payments under Section II.E. of this plan, sufficient funds, other than funds transferred by other governmental units to the Medicaid indigent care trust fund, that equal an amount equal to twenty-six million dollars ($26,000,000) minus the product of twenty-six million dollars ($26,000,000) multiplied by the federal medical assistance percentage.

D. Municipal Disproportionate Share Payment Adjustments

For each state fiscal year ending on or after June 30, 1998, OMPP will make municipal disproportionate share payments to qualifying municipal disproportionate share hospitals as follows:

A pool not exceeding the sum of the hospital specific limits for all qualifying hospitals shall be distributed to each qualifying hospital in an amount which equals to the extent possible, but in no case exceeds, the hospital's hospital-specific limit provided under 42 U.S.C. 1396r-4(g). Each hospital's "hospital specific limit" is the sum of all costs for services provided to uninsured patients, less any cash payments made by them, and all costs for services provided to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan. The hospital-specific limit for each hospital, in each state fiscal year, shall be determined by the office taking into account data provided by the hospital that is considered reliable by the office, based on a system of periodic audits, and the use of trending factors applied to such data. The office may require independent certification of data provided by a municipal disproportionate share hospital to determine the hospital's hospital-specific limit.

The OMPP may, however, adjust the municipal disproportionate share payment specified above as provided for in 42 CFR 447.297(d)(3), allowing the state to make additional municipal disproportionate share expenditures after the end of each federal fiscal year that relate back to the prior federal fiscal year. Each eligible hospital may receive an additional municipal disproportionate share payment adjustment, if:

(1) additional funds are made available which are eligible for federal financial participation pursuant to 42 U.S.C. 1396b(w)(6)(A) and 42 CFR §433.51; and

(2) the total disproportionate share payments to each individual hospital, and all qualifying hospitals in the aggregate, do not exceed the limits provided by federal law and regulation.

For the state fiscal year ending June 30, 2000, the total municipal disproportionate share payments available to qualifying municipal disproportionate share hospitals shall be twenty-two million dollars ($22,000,000), except, as provided in Section III.G. of this plan.

E. Community Mental Health Center Disproportionate Share Payment Adjustments.

For each state fiscal year ending after June 30, 1997, OMPP will make community mental health center disproportionate share payments to qualifying community mental health centers as follows:

Each qualifying community mental health center shall receive an amount determined by subtracting the amount paid to the community mental health center during the state fiscal year by the county treasurer of the county in which the community mental health center is located, as authorized by the county executive and appropriated by the county fiscal body, or funds received by the community mental health center from other county sources, from an amount consisting of the foregoing amount divided by the state medical assistance percentage applicable to the state fiscal year.

The OMPP may, however, adjust the community mental health center disproportionate share payment specified above as provided for in 42 CFR 447.297(d)(3), allowing the state to make additional community mental health center disproportionate share expenditures after the end of each federal fiscal year that relate back to the prior federal fiscal year. Each eligible community mental health center may receive an additional community mental health center disproportionate share payment adjustment, if:

(1) funds are made available by one or more counties which have been certified as expenditures eligible for financial participation under 42 U.S.C. 1396(w)(6)(A) and 42 CFR 433.51;

(2) the total disproportionate share payments to each individual community mental health center do not exceed the institution specific limit provided under 42 U.S.C. 1396r-4(g); and

(3) the total disproportionate share payments to community mental health centers do not result in total disproportionate share payments in excess of the state limit on such expenditures for institutions for mental diseases under 42 U.S.C. 1396r-4(h).

The office shall assist a county treasurer in making the certification described in III.E.(1) above.

The institution specific limit for a state fiscal year shall be determined by the office taking into account data provided by the community mental health center that is considered reliable by the office based on a system of periodic audits, and the use of trending factors applied to such data. The office may require independent certification of data provided by a community mental health center to determine the institution specific limit.

The office may reduce, on a pro rata basis, payments due to community mental health centers under this section for a fiscal year if necessary to avoid exceeding the state limit on disproportionate share expenditures for institutions for mental diseases. Further, a payment under this provision may be recorded by the office from the community mental health center if federal financial participation is disallowed for the funds certified under IC 12-29-1-7(b) upon which such payment was based.

For the state fiscal year beginning July 1, 1999, and ending June 30, 2000, the total community mental health center disproportionate share payments available under this section to qualifying community mental health center disproportionate share providers, is six million dollars ($6,000,000), except as provided in Section III.G. of this plan.

F. Hospital Specific Limit on Disproportionate Share Payments

Total disproportionate share payments to a provider shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year shall be determined by the office taking into account data provided by each hospital that is considered reliable by the office based on a system of periodic audits, and the use of trending factors applied to such data. The office may require independent certification of data provided by a hospital or other qualifying provider to determine the provider's hospital specific limit. Each hospital's and each CMHC's "hospital specific limit" is the sum of all costs for services provided to uninsured patients, less any cash payments made by them, and all costs for services provided to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan.

G. State Limit on Disproportionate Share Payments

1. For the state fiscal year ending June 30, 2000, if the state exceeds the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)) or the state limit on disproportionate share expenditures for institutions for mental diseases (as defined in 42 U.S.C. 1396r-4(h)), the state shall pay providers as follows:

   (1) The state shall make disproportionate share provider payments to municipal disproportionate share providers qualifying under Section II.(G) of this plan, until the state exceeds the state disproportionate share allocation. The total amount paid to municipal disproportionate share providers under this plan for the state fiscal year ending June 30, 2000, may not exceed twenty-two million dollars ($22,000,000), except as provided elsewhere in this section.

   (2) After the state makes all payments under subdivision (1), if the state fails to exceed the state disproportionate share allocation, the state shall make community mental health center disproportionate share provider payments to providers qualifying under Section II.(H) of this plan. The total paid to the qualified community mental health center disproportionate share providers under section 9(a) of this chapter, may not exceed six million dollars ($6,000,000) for the state fiscal year ending June 30, 2000, except as provided elsewhere in this section.

   (3) After the state makes all payments under subdivision (2), if the state fails to exceed the state disproportionate share allocation, the state shall make disproportionate share provider payments to acute care hospitals licensed under IC 16-21 and qualifying under Section II.(E) of this plan.

2. For each state fiscal year beginning after June 30, 2000, if the state exceeds the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)) or the state limit on disproportionate share expenditures for institutions for mental diseases (as defined in 42 U.S.C. 1396r-4(h)), the state shall pay providers as follows:

   (1) The state shall make municipal disproportionate share provider payments to providers qualifying under Section II.(G) of this plan, until the state exceeds the state disproportionate share allocation.

   (2) After the state makes all payments under subdivision (1), if the state fails to exceed the state disproportionate share allocation, the state shall make disproportionate share provider payments to providers qualifying under Section II.(E) of this plan.

   (3) After the state makes all payments under subdivision (2), if the state fails to exceed the state disproportionate share allocation, the state shall make community mental health center disproportionate share provider payments to providers qualifying under Section II.(H) of this plan.

The dollar limitations imposed by this section on disproportionate share payments to municipal disproportionate share hospitals and community mental health center disproportionate share providers shall not be applicable in the event that additional disproportionate share expenditures are made under the provisions of this plan after the end of a federal fiscal year, relating back to a prior federal fiscal year. An eligible provider may receive an additional disproportionate share payment adjustment as authorized by this Plan, if:

(1) additional funds are made available which are eligible for federal financial participation pursuant to 42 U.S.C. 1396b(w)(6)(A) and 42 CFR §433.51; and

(2) the total disproportionate share payments to the individual provider, and all qualifying providers in the aggregate, to not exceed the limit provided by federal law and regulation.

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Attachment 4.19A

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IV. DISPROPORTIONATE SHARE PAYMENT EXAMPLES

To illustrate the payment methodology proposed by TN _____ for disproportionate share payments, the following examples are displayed within this plan.

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Example 1 - **Provider is an acute care hospital licensed under I.C. 16-21 that qualifies as a disproportionate share provider**

Facts— Hospital's Medicaid inpatient utilization rate = 28% and exceeds one standard deviation from the statewide mean Medicaid IUR which is 15%.

Hospital is determined to be a disproportionate share acute care hospital under Section II.(B) of this plan, that qualifies for a disproportionate share payment under section II.(E) of this plan. Hospital qualified as a disproportionate share provider in state fiscal year 1998 and continues to qualify as a disproportionate share provider in the state fiscal year for which a distribution is being made.

Hospital's hospital specific limit is $11,000,000.

The hospital's disproportionate share payment is equal to 100% of its hospital-specific limit, or .....**$11,000,000**.

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Example 2 - Provider is a state mental health institution (state psychiatric hospital) that qualifies for DSH payments (for SFYE 6-97)

Facts---- Hospital's low-income utilization rate = 40%. The provider meets the definition found at II(B) of the plan, and qualifies to participate in DSH basic pool (4) as described at Section III(A)(2) of this plan.

This pool had $191,000,000 available for distribution in the SFYE 6-95 and was adjusted for SFYE 6-96 by a ratio as provided for on page 7 of this plan resulting in a reduction of 5% of the 1995 pool amount to a new pool amount of $181,450,000 for FYE 6-96. This pool was again adjusted for SFYE 6-97 as provided for on page 7 of the plan by an increase of 12% from the SFY 6-96 base to $203,224,000 (181,450,000 x 112%).

The hospital's total inpatient days equal 1,000. The distribution factor is the low income utilization rate times the total inpatient days. (40 x 1000) = 40,000.

All qualifying hospital in the pool have a sum total distribution factor of 400,000. This hospital's percentage of the total distribution is 40,000/400,000 or 10%.

This hospital's distribution for DSH for SFYE 6-97 is set at $20,322,400. (203,224,000 x 10%).

The hospital has been determined to have a Medicaid shortfall and uncompensated charity care total, for the hospital's fiscal year ending in SFY 1997, of $13,400,000. The OBRA '93 hospital specific DSH limit for '97 is set at $13,400,000 (100% of the determined total).

The hospital receives **$13,400,000** rather than $20,322,400 based on the OBRA '93 DSH limit.

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All disproportionate share payments made in accordance with these examples and under the provisions of this disproportionate share payment methodology will be made subject to all applicable federal DSH spending caps and any Indiana specific DSH caps, and specific provider payments will not exceed the individual provider's OBRA '93 calculated DSH payment limit. The "hospital's OBRA '93 calculated DSH payment limit" is the sum of all costs for services provided to uninsured patients, less any cash payments made by them, and all costs for services provided to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan. The formula appears as follows:

DSH LIMIT = M + U

M = Cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan

U = Cost of services to uninsured patients, less any cash payments made by them

State: Indiana

Attachment 4.19A

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TN 00-004
Supersedes
TN 98-011

Approval Date SEP 20 2000 Effective 4/1/00

Attachment 4.19B

Page 2.1

MEDICAID OUTPATIENT PAYMENTS FOR SAFETY-NET HOSPITALS

"Safety-net hospital", for purposes of this section, means an acute care hospital, licensed under IC 16-21, the Indiana hospital licensure statute, and qualified under Section II.E. of this plan as a disproportionate share hospital.

A. For the state fiscal years ending on or after June 30, 2000, safety-net hospitals with more than 150 interns and residents, located in a city with a population of over 600,000, and safety-net hospitals which are the sole disproportionate share hospital in a city located in a county having a population of more than four hundred thousand (400,000) but less than seven hundred thousand (700,000), which hospitals are also historical disproportionate share hospitals, shall receive reimbursement, subject to the terms of subsection (B) of this section, in an amount calculated by the office from the hospital's cost report filed with the office for the hospital's fiscal period ending during the state fiscal year, equal to the difference between:

(1) the amount of Medicaid payments to the hospital, excluding payments under Section III of this Plan, for Medicaid outpatient services provided by the hospital during the hospital's fiscal year, and

(2) an amount equal to the lesser of the following:

(A) The hospital's customary charges for the services described in subdivision (1).

(B) A reasonable estimate by the office of the amount that would be paid for the services described in subdivision (1) under Medicare payment principles.

The office may also make payments to all other safety-net hospitals in the manner provided in subsection A. of this section, subject to the provisions of subsection B. of this section.

B. Payments described in subsection A. of this section are subject to the availability of funds representing expenditures eligible for federal financial participation pursuant to 42 U.S.C. 1396b(w)(6)(A) and 42 CFR §433.51.

This new payment methodology will only apply for Medicaid services on or after April 1, 2000, but will be calculated as set forth in this section. For the state fiscal year ending on June 30, 2000, the state may reimburse, under this section, each safety-net hospital eligible for such reimbursement in an amount not to exceed one-fourth of the amount calculated under the formula described in this section. For state fiscal years ending after June 30, 2000, the state may reimburse, under this section, each safety-net hospital eligible for such reimbursement in an amount up to one hundred percent (100%) of the amount calculated under the formula described in this section.

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